STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155137	A. BUILDING 00 B. WING	08/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-VALPARAISO	251 STURDY ROAD VALPARAISO, IN46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 15, 16, 17, 18, 19, and 23, 2011 Facility number: 000062 Provider number: 155137 AIM number: 100271400 Survey team: Regina Sanders, RN-TC Sheila Sizemore, RN (August 15, 18, 19, and 23, 2011) Kelly Sizemore, RN (August 17, 18, 19, and 23, 2011) Census bed type: SNF/NF: 79 Total: 79 Census payor type: Medicare: 13 Medicaid: 56 Other: 10 Total: 79 Sample: 16 Supplemental: 5 These deficiencies also reflect state	F0000	The facility objects to the allegations of non-compliance in the Statement of Deficiency and disagrees with both the findings of non-compliance and the level of deficiency cited. Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as admission of interest against the facility, the Administrator, or any employees, agents, or other individuals who draft, or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or any agreement of any kind by te facility of the truth o any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.Accordingly, the facility has prepared and submitted this plan of Correction prior to resolution of appeal of this matter, solely becaue of the requirements under State and Federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in the title 18 and Title 19 programs. The submission of this Plan of Correction within this time frame should in no way be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on August 24, 2011, by Bev Faulkner, RN		considered or construed as an agreement with the allegations of non-compliance or admissions by the facility.This Plan of Correction shall constitute the facility's credible allegation of compliance.	
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically-related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, related to not obtaining follow up psychiatric evaluations and assessments for 2 of 6 residents reviewed for psychiatric evaluations in a sample of 16. (Residents #41 and #64) Findings include: 1. Resident #41's record was reviewed on 08/17/11 at 8 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and psychotic disorder.	F0250	1. Resident #41 - Social Services Director (SSD) reviewed documentation on chart and none was found to confirm that visitation in common areas were not necessary and had been discontinued in July 2011.SSD continuously assesses resident by direct observation and reports completed by staff for any resident displaying behavioral manifestations indicating mood disturbance or unusual medically related issues. Interventions are implemented as needed.2. Whole house audit will be completed on residents for psychosocial needs.3. SSD will implement social service audit tool. Administrator/Designee will do audit weekly for 4 weeks.B. Resident #64 - records were reviewed and no follow up documentation by psych services	09/09/2011

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	A,"Facility Incident Reporting Form," dated 05/22/11, indicated, "...On 5/22/11 at approx. (approximately) 6:30 p.m., CNA was walking past (resident name) room and heard resident's husband yelling. CNA was unable to hear the specific words being yelled, so CNA looked in and saw resident's husband pick up a cloth item, like a wash cloth, and stated, 'I don't want to hear anything else. Shut-up.' At that time, CNA noted that resident's husband pushed the cloth item into resident's mouth. The CNA alerted one of the nurses on duty...husband was preparing to leave...Nurse manager noted that resident should be in vision if resident's husband was present and would only be able to visit at this time in a common area...Ombudsman met with resident's family and staff. Resident's family agreed to continued supervised meetings...until an assessment by social services is completed in two weeks...Resident to be seen by psychiatrist on next visit...Care plan in place." The resident's record lacked documentation to indicate an assessment by the Social Service Director had been completed to determine if supervised visits were still required. There was a lack of documentation in the		noted. 2. Whole house audit will be completed and any resident needing follow up psych services will have dates to be seen by psych timely. 3. SSD has initiated QA/A audit tool. This will be reviewed weekly by Administrator/Designee for 4 weeks. Administrator to in-service SSD on timely documentation for charting accuracy/completeness. 4. Results of audits/observations will be reported to the QA/A Committee for 6 months. 5. 9-9-2011.	

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resident's record to indicate the resident had been seen by a Psychiatrist and/or mental health services until 08/10/11.

There was a lack of documentation in the resident's record to indicate what was discussed at the meeting with the family and the Ombudsman.

During an interview on 08/17/11 at 10:30 a.m., the Social Service Director (SSD) indicated the assessment to determine if supervised visits were still required was not in the resident's record. She indicated the Ombudsman had taken care of the assessment when he came in. She indicated there were no notes about the Ombudsman meeting in the resident's record and she was unsure where the notes about the meeting were. She indicated the Psychiatrist comes in every month. She indicated the resident had not been seen until 08/10/11.

During a telephone interview on 08/17/11 at 1:50 p.m., Ombudsman #1 indicated during the meeting, the family and husband agreed to supervised visits. He indicated Ombudsman #2 had met with the family and facility on 05/25/11. He indicated Ombudsman #2 came back to the facility and met with staff members and was informed the resident's husband had not showed any abusive tendencies

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	and the visits were still supervised. He indicated Ombudsman #2 suggested the visits continue in a public area. He indicated the Ombudsman's office make suggestions to the facility, the facility is to decide if they are going to follow the suggestions. 2. Resident #64's record was reviewed on 08/15/11 at 1:25 p.m. The resident's diagnoses included, but were not limited to, bipolar disease and depression. A mental health note, dated 05/03/11, indicated to decrease the resident's Prozac (anti-depressant) 10 milligrams every night and to follow up in four weeks to assess moods and sleep. There was a lack of documentation to indicate the four week follow up had been completed. During an interview on 08/15/11 at 5:15 p.m., the Director of Nursing indicated there had been no follow up on the resident's moods and sleep. She indicated it was the responsibility of the Social Service Director to ensure the follow up was completed. 3.1-34(a)			

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review and interview, the facility failed to ensure residents' care plans were developed and updated, related to supervised visits and PICC (peripherally inserted central catheter) lines for 3 of 16 residents reviewed for care plans in a sample of 16.	F0280	1. The care plan for resident #30 was implemented immediately. Resident #58 care plan was implemented immediately. 2. Whole house audit of care plans for any PICC/IV lines was completed and inaccuracies noted. 3. The Director of Clinical Education (DCE) will in-service	09/09/2011

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	(Residents #30, #41, and #58) Findings include: 1. Resident #41's record was reviewed on 08/17/11 at 8 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and psychotic disorder. A, "Facility Incident Reporting Form", dated 05/22/11, indicated, "...On 5/22/11 at approx. (approximately) 6:30 p.m., CNA was walking past (resident name) room and heard resident's husband yelling. CNA was unable to hear the specific words being yelled, so CNA looked in and saw resident's husband pick up a cloth item, like a wash cloth, and stated, 'I don't want to hear anything else. Shut-up.' At that time, CNA noted that resident's husband pushed the cloth item into resident's mouth. The CNA alerted one of the nurses on duty...husband was preparing to leave...Nurse manager noted that resident should be in vision if resident's husband was present and would only be able to visit at this time in a common area...Ombudsman met with resident's family and staff. Resident's family agreed to continued supervised meetings...until an assessment by social services is completed in two weeks...Resident to be seen by		nursing staff on updating care plans. The Director of Nursing Services (DNS)/Designee will audit care plans as needed for new IV/PICC lines to insure they are in place. 4. The results of audits will be reviewed at QA/A meetings for 6 months. 5. 9-9-2011.	

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	psychiatrist on next visit...Care plan in place." A care plan, dated 08/31/10 and revised 06/01/11, indicated, "I am sometimes impacted by my family's attempt to 'motivate' me. My psychosocial well-being fluctuates as a result of their interaction, as well as my own feelings of loss." The interventions indicated, "I will see (mental health group name) and psych (psychiatric) services as appropriate. I will allow for staff to redirect family as appropriate. I will accept staff support. I will participate in care plans with my family as appropriate for my well-being. I will verbalize my feelings to staff and family. I will accept appropriate meds (medication), inform MD and psych of significant concerns." There was a lack of documentation to indicate the resident had a care plan for possible abuse from her husband and visits with her husband were to be in the common areas of the facility. During an interview on 08/17/11 at 10:30 a.m., the Social Service Director indicated the care plan states she will allow staff to redirect as appropriately. She indicated the care plan did not state to supervise the husband's visits and to keep visits in the common area.			

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2. During an observation on 08/15/11 at 2:30 p.m., with LPN #4 present, Resident #58 was sitting in his recliner in his room. There was a PICC line in the resident's right upper arm.

Resident #58's record was reviewed on 08/16/11 at 11:35 a.m. The resident's diagnoses included, but were not limited to, dementia and osteomyelitis (bone infection)

A physician's order, dated 07/14/11, indicated a PICC line was to be placed due to intravenous therapy.

A progress note from the hospital indicated the PICC line had been placed on 07/18/11.

There was a lack of documentation to indicate the resident had a care plan for the PICC line.

During an interview on 08/16/11 at 1:55 p.m., RN #3 indicated there was no care plan for the PICC line.

3. During an observation on 08/18/11 at 2:08 p.m., Resident #30 was sitting in his wheelchair in his room. There was a PICC line in his right upper arm. The resident was admitted into the facility from the

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	hospital on 08/03/11. Resident #30's record was reviewed on 08/19/11 at 8 a.m. The resident's diagnoses included, but were not limited to, urinary tract infection and hypertension. The Physician's Recapitulation Orders, dated 08/03/11, indicated the resident had a PICC line upon admission into the facility. There was a lack of documentation to indicate the resident had a care plan for the PICC line. During an interview on 08/19/11 at 8:55 a.m., the Assistant Director of Nursing indicated there was no care plan for the PICC line. 3.1-35(c)(1) 3.1-35(d)(2)(B)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician's orders were followed, related to dialysis for 1 of 1 resident with dialysis in a sample of 16. (Resident #63) Findings include: Resident #63's record was reviewed on 08/16/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease and hypertension. A physician order, dated 07/08/11, indicated to complete the peritoneal dialysis as ordered if the resident's weight was 230-238 and if the systolic blood pressure was between 100-160. The orders indicated to call the dialysis company if the resident's weight was below 230 or above 238 or systolic blood pressure was below 100 or above 160. The resident's pre-dialysis weights/blood pressures per the dialysis flowsheet were as follows: 07/10/11- 239	F0282	1. Resident #63 medical record was reviewed. In-service was completed on 8-9-2011 regarding BP and weight parameters and notifying dialysis clinic. Review of record from that day forward shows accurate implementation of orders.2. No peritoneal dialysis residents are in the building.3. All nurses will be inserviced on communicating per dialysis company orders. DCE/Designee will monitor dialysis flow sheet 5 times weekly to insure timely communication.4. Resuts of audits will be reviewed at QA/A meetings for 6 months.5. 9-9-2011.	09/09/2011

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	07/13/11- 240.4 07/14/11- 240.2 07/15/11- blood pressure, 96/54 07/21/11- 227.2 07/23/11- 228.2 07/25/11- 227 07/26/11- 229.4 07/28/11- 229.8 The flow record indicated the dialysis was completed on the above dates. There was a lack of documentation to indicate the dialysis company had been notified of the weights and blood pressures outside of the ordered parameters. A physician's order, dated 07/29/11, indicated to complete the peritoneal dialysis as ordered if the resident's weight was between 225-238 or if the systolic blood pressure was between 100-160. The orders indicated to call the dialysis company if the resident's weight was below 225 or above 238 or the systolic blood pressure was below 100 or above 160. The dialysis flow sheet indicated resident's pre-dialysis weight on 07/31/11 was 224.8 and 08/07/11 was 224.4 and blood pressure was 97/51. The flow sheet indicated the dialysis was completed on both evenings. There was a lack of documentation to indicate the dialysis company had been notified of the weight and blood pressure prior to the dialysis being completed. During an interview on 08/16/11 at 10:40 p.m. the Director of Nursing indicated the dialysis company was not being notified.			

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	3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a resident receiving peritoneal dialysis was provided the dialysis treatment only when weights and blood pressure readings were within the ordered parameters as the facility failed to notify a dialysis company of weights and blood pressure readings outside the ordered parameters to ensure the treatment was still warranted for 1 of 1 resident with dialysis in a sample of 16. (Resident #63) Findings include: Resident #63's record was reviewed on 08/16/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease and hypertension. A physician order, dated 07/08/11, indicated to complete the peritoneal	F0309	1. Flow sheets with weights and blood pressures were faxed to dialysis company daily. Flow sheets for resident #63 were reviewed. Inaccuracies were noted and an inservice was completed on 8-09-2011. After the in service was completed no further weights or blood pressures were outside the ordered parameters without communication to dialysis company. 2. House review indicates no peritoneal dialysis residents are in the facility.3. All licensed nurses will be inserviced on communicating with the dialysis company per their orders. DCE or designee will audit the peritoneal dialysis flow sheet 5 x weekly to ensure that communication is done per orders. 4. The results of these audits will be reported to the QAA committee x 6 months. 5. 9/9/2011	09/09/2011

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	dialysis as ordered if the resident's weight was 230-238 and if the systolic (top number) blood pressure was between 100-160. The orders indicated to call the dialysis company if the resident's weight was below 230 or above 238 or systolic blood pressure was below 100 or above 160. The resident's pre-dialysis weights/blood pressures per the dialysis flowsheet were as follows: 07/10/11- 239 07/13/11- 240.4 07/14/11- 240.2 07/15/11- blood pressure, 96/54 07/21/11- 227.2 07/23/11- 228.2 07/25/11- 227 07/26/11- 229.4 07/28/11- 229.8 The flow record indicated the dialysis was completed on the above dates. There was a lack of documentation to indicate the dialysis company had been notified of the weights and blood pressures outside of the ordered parameters. A physician's order, dated 07/29/11, indicated to complete the peritoneal dialysis as ordered if the resident's weight			

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	was between 225-238 or if the systolic blood pressure was between 100-160. The orders indicated to call the dialysis company if the resident's weight was below 225 or above 238 or the systolic blood pressure was below 100 or above 160. The dialysis flow sheet indicated resident's pre-dialysis weight on 07/31/11 was 224.8 and 08/07/11 was 224.4 and blood pressure was 97/51. The flow sheet indicated the dialysis was completed on both evenings. There was a lack of documentation to indicate the dialysis company had been notified of the weight and blood pressure prior to the dialysis being completed. During an interview on 08/16/11 at 10:40 p.m., the Director of Nursing indicated the dialysis company was not being notified. During a telephone interview on 08/18/11 at 8:45 a.m., the dialysis company's RN indicated the weights and the blood pressures should have been called to the dialysis company prior to completing the dialysis. 3.1-37(a)			

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F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, record review and interview, the facility failed to ensure dressing changes and measurements were completed weekly on a PICC (Peripherally Inserted Central Catheter) line for 1 of 2 residents with PICC lines in a sample of 16. (Resident #58) Findings include: During an observation on 08/15/11 at 2:30 p.m. with LPN #4 present, Resident #58 was sitting in his recliner in his room. There was a PICC line in the resident's right upper arm. There was no date on the dressing to the PICC line to indicate when the dressing had last been changed. There was blood in the PICC line and on the dressing.	F0328	1. Resident #58 was assessed for any negative outcome and none noted. Order was corrected immediately. 2. All residents with IV or PICC lines were reviewed and corrections were completed as needed. 3. All licensed staff will be re-educated on correct physician orders for IV and/or PICC lines. The DNS or designee will monitor orders for new IV or PICC lines as needed. This will be on going. 4. The results of these observations will be reported to the QAA commettee x 6 months.5. 9/09/2011	09/09/2011

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	Resident #58's record was reviewed on 08/16/11 at 11:35 a.m. The resident's diagnoses included, but were not limited to, dementia and osteomyelitis (bone infection). A physician's order, dated 07/14/11, indicated a PICC line was to be placed due to intravenous therapy. A progress note from the hospital indicated the PICC line had been placed on 07/18/11. An order from the hospital, dated 07/18/11, indicated to change the dressing to the PICC line every seven days, or if heavily soiled. A nurses' note, dated 08/04/11 at 17:54 (5:54 p.m.), indicated, "Picc line dressing changes...Bilateral lumens flush well and caps changed." There was a lack of documentation to indicate the resident's PICC line dressing had been changed weekly and the external length of the catheter had been measured. During an interview on 08/16/11 at 11:30 a.m., the Assistant Director of Nursing indicated she had changed the PICC dressing on 08/15/11. She indicated she wrote and transcribed an order to change			

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	the PICC dressing every week. A facility policy, dated 04/08, titled, "Dressing Change For Vascular Access Devices", received from the Assistant Director of Nursing as current, indicated, "...5...Initial dressing with Biopatch (clear dressing) at the site may be left in place for 7 days unless the Biopatch is saturated or the dressing is otherwise compromised...Procedure...Assess site:...external length of catheter..." 3.1-47(a)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure food items and equipment were stored to prevent contamination, failed to ensure food items were dated when opened or had a use by date and that supplements	F0371	The facility will store, prepare, distribute and serve food under sanitary conditions.1. The plastic bag of orange gelatin lying on the floor in the dry food area was picked up and discarded immediately.2. There was an	09/09/2011

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	were discarded when expired. These practices had the potential to affect 79 of 79 residents who received meals from the kitchen and/or 13 of 52 residents on the South Hall who received supplements. (Kitchen and South Hall Nutritional Pantry) Findings include: During the initial tour on 8/15/11 beginning at 8:50 a.m., with the Dietary Manager and the District Food Manager the following was observed in the kitchen: A. Kitchen 1. There was a plastic bag of orange gelatin laying on the floor in the dry food area. 2. There was an open box of lasagne with a loose covering of plastic stored on the bottom shelf next to a dirty broom and a dust pan. 3. There were two boxes of bowls stored on the floor. 4. The meat slicer had dried food debris on the blade and base. 5. There was a black purse sitting on the bottom shelf of the food prep table.		open box of lasagna with a loose covering of plastic stored on the bottom shelf next to a dirty broom and dust pan which was discarded immediately.3. There were 2 boxes of bowls stored on the floor unopened which were taken to the disposable closet immediately.4. The meat slicer with dried flood on the blade and a dirty base were cleaned/sanitized immediately.5. The black purse sitting on the bottom shelf of the food prep table was removed and taken immediately to the staff member's car.6. The plastic tops of the flour and rice bins were dirty and sticky to touch. The DSM indicated the red substance looked like punch. All spice bin lids were cleaned immediately.7. Inside the flour bin was a brown substance mixed in with the flour. The DSM indicated that cocoa had been spilled in the bin. The flour in the bin was disposed of and the bin was cleaned, sanitized and free of all debris.8. There were 3 undated pitchers of whole, skim and 2% milk in the reach-in cooler that were discarded immediately.9. There was an undated bag of opened non-dairy whipped topping in the reach-in cooler that was immediately discarded.10. There was a plastic bag of shredded cheese with the open date of 8-5-11 that was discarded immediately.11. The front vent of the ice machine was dirty, sticky	

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	6. The plastic tops of the flour and rice bins were dirty and sticky to touch. The Dietary Manager indicated the red substance looked liked punch. 7. Inside the flour bin there was a brown substance mixed in with the flour. The Dietary Manager indicated "It looks like coco has been spilled." 8. There were three undated pitchers of whole, skim, and two percent milk in the reach in cooler. 9. There was an undated bag of opened non-dairy whipped topping in the reach in cooler. 10. There was a plastic bag of shredded cheese with the open date of 8/05/11. 11. The front vent to the ice machine was dirty, dusty and sticky. 12. The railings on the wire rack used for pan storage were dirty and sticky. 13. The bottom of the food steamer was dirty with food spills. 14. The garbage can sitting by the oven was overflowing with food, paper, and plastic. The lid to the garbage can was		and dusty. This was cleaned/sanitized immediately of any dust, dirt and stick residue it had.12. The railings on the wire rack used for pan storage were dirty and sticky. All racks were cleaned immediately of any dust and grime.13. The bottom of the food steamer was dirty with food spills. This was cleaned immediately of any grease buildup.14. The garbage can sitting by the oven was overflowing with food, paper and plastic. The lid to the garbage can was sitting sideways on top. Trash was immediately discarded.15. All outdated cans of 2Cal in the south unit nutritional pantry were immediately discarded.2. Food preparation/storage procedures will be monitored daily for 4 weeks by DSM/Designee. Administrator/Designee will conduct onging weekly audits.3.Results of audits will be reviewed in QA/A meeting for 6 months.4. 9-9-11.	

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	sitting sideways on top. A facility policy, titled "Storage of Refrigerated Foods," dated, 2002, indicated "...Monitor daily for expiration dates or use by dates and discard all outdated...." B. During the environmental tour, on 8/17/11 at 1:30 p.m., with the Maintenance Director and Housekeeping Director, the following was observed: South Hall Nutritional Pantry: 1. There were 18 cans of 2 cal (a nutritional supplement), 4 in the refrigerator and 14 on the shelf, with an expiration date of 08/01/11. During an interview at the time of the observation, the Housekeeping Director indicated "we will discard them now." 3.1-21(i)(2) 3.1-21(i)(3)			

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F0465 SS=D	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure safe, sanitary conditions related to dirty floors throughout 1 of 1 kitchen. (kitchen). Findings include: During the initial kitchen tour on 8/15/11 at 8:50 a.m., with the Dietary Manager and the District Food Manager, the floors throughout the kitchen were observed to have a black, sticky substance along the corners and baseboard, under the food storage racks, sinks, food prep tables, and stove. The center of the floors had debris and food spills. During an interview on 8/15/11 at 8:50 a.m., the Dietary Manager indicated she would inservice the kitchen staff on how to mop. During an interview on 8/15/11 at 9:00 a.m., the Dietary Manager indicated she had been trying to get housekeeping in to clean the floors. 3.1-19(f)	F0465	1. Kitchen floor was mopped, stripped and rewaxed on 8-15-11. Mop solution changed to ammonia free chemical which does not dull floor wax. 2-3. Dietary staff inserviced by Dietary Service Manager (DSM) concerning proper sweeping and mopping techniques. Kitchen staff will sweep/mop floor erevy shift/daily and detail corners, edges and under equipment weekly.4. Dietary staff will sign off on floor care checklist each shift/daily. DSM to inspect and sign off on completion daily. Environmental Services Manager (ESM) to initiate quarterly schedule of floor waxing and sign off on floor care quarterly checklist. Administrator/Designee to conduct ongoing sanitation/floor care checks 3 times weekly. Results to be reviewed at QA/A meetings for 6 months.5. 9-9-2011.	09/09/2011

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F0514 SS=E	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review and interview, the facility failed to ensure medical records were complete and accurate related to, physicians orders, plan of care meetings, assessment forms, and psychiatric progress reports for 4 of 16 residents reviewed for	F0514	1. A. Resident # 41 records reviewed by SSD and documentation updated. B. Resident #41 order corrected in computer immediately and placed on chart. Resident was receiving correct diet. All diets were audited and any corrections needed were completed. 2. A. Resident #46 order was for accu-check once daily with sliding scale insulin. Insulin had been administered correctly since change order received to change accu-checks from 4 x daily to 1 time daily; however, body of order contained "QID" in it. Resident #46 orders were reviewed and corrected immediately. B. Resident # 41 records were reviewed and no follow up documentation by psych services was noted. 3. Resident # 58 physician orders were reviewed and corrected. All residents with PICC lines or IVs were reviewed	09/09/2011

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	complete and accurate medical records in a sample 16. (Residents #41, #46, #58, and #67) Findings include: 1. Resident #41's record was reviewed on 08/17/11 at 8 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and psychotic disorder. A). A, "Facility Incident Reporting Form", dated 05/22/11, indicated, "...On 5/22/11 at approx.		and any corrections required were made.4. Resident # 67 Clinical Health Status Assessment were reviewed. 2. Whole house audit will be completed on residents for psychosocial documentation. Whole house audit was completed on residents diet orders. Diet orders noted to be correct. Reviewed all insulin orders for last 30 days to insure all orders are accurate. Going forward from date of exit all Clinical Health Status Assessements will be reviewed by DNS or designee prior to be placed in charts to insure completion of assessments. 3. SSD will implement a social service audit tool to be completed 5 x weekly. Admin/designee will monitor audits weekly x 4 weeks. Licensed staff will be inserviced on correct procedure for writing physician orders. MAR will be reviewed monthly by DNS or designee to insure accuracy of insulin orders. Clinical Health Status assessments will continue to be completed on admission, quarterly, annually and with significant change per MDS schedule to track when these are due. Prior to being placed in charts assessments will be reviewed by DNS or designee to ensure completion. 4. The results of these audits and observations will be reported to the QAA committee x 6 months. 5. 9-9-2011	

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	(approximately) 6:30 p.m., CNA was walking past (resident name) room and heard resident's husband yelling. CNA was unable to hear the specific words being yelled, so CNA looked in and saw resident's husband pick up a cloth item, like a wash cloth, and stated, 'I don't want to hear anything else. Shut-up.' At that time, CNA noted that resident's husband pushed the cloth item into resident's mouth. The CNA alerted one of			

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	the nurses on duty...husband was preparing to leave...Nurse manager noted that resident should be in vision if resident's husband was present and would only be able to visit at this time in a common area...Ombudsman met with resident's family and staff. Resident's family agreed to continued supervised meetings...until an assessment by social services is completed in two weeks...Resident to be seen by psychiatrist			

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	on next visit...Care plan in place." There was a lack of documentation in the resident's record to indicate what was discussed at the meeting with the family and the Ombudsman. During an interview on 08/17/11 at 10:30 a.m., the Social Service Director (SSD) indicated there were no notes about the Ombudsman meeting in the resident's record and she was unsure where the notes			

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	about the meeting were. B) During an observation of the noon meal on 08/15/11 at 12:15 p.m., Resident #41 received a regular consistency diet. The resident's family brought in regular consistency food for the resident for her evening meal at 6:17 p.m., on 08/15/11. The Physician's Recapitulation Orders, dated 08/02/11, indicated the resident had an order for a regular puree diet, originally ordered on			

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	07/22/11. The resident's dietary card indicated the resident should receive a regular diet. During an interview on 08/19/11 at 9:10 a.m., the Dietary Manager indicated she had received a slip from nursing on 07/25/11 to change the resident's diet to a regular consistency. During an interview on 08/19/11 at 9:15 a.m., LPN #6 indicated she remembered talking to			

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	the resident's physician about the diet. She indicated she did not know why there was not an order in the medical record or computer for the dietary order change. During an interview on 08/19/11 at 9:50 a.m., the Assistant Director of Nursing indicated an order for the diet change was not in the resident's record or in the computer for the resident. She indicated the order was received on 07/25/11. 2. Resident #46's record			

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	was reviewed on 08/17/11 at 2:15 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and depression. A) A physician's order, dated 06/23/11, indicated Novolog insulin was to be administered daily. The order also indicated accu-checks (blood sugar checks) four times a day and a sliding scale of insulin (insulin administered by the results of the blood sugar).			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident's Medication Administration Record (MAR), dated 08/11, indicated the resident was getting an accu-check completed daily and Novolog insulin was given daily per the sliding scale. During an interview on 08/18/11 at 8:40 a.m., the Director of Nursing indicated the order was not written correctly. She indicated the accu-check should only be completed daily.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155137	A. BUILDING 00 B. WING	08/23/2011

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	B) A psychiatric note, dated 05/03/11, indicated for a follow up in two weeks. There was a lack of documentation to indicate the follow up had been completed in two weeks. During an interview on 08/17/11 at 10:10 a.m., the Social Service Director indicated the resident's psychiatric progress notes had not been filed in the resident's record yet.			

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	3. Resident #58's record was reviewed on 08/16/11 at 11:35 a.m. The resident's diagnoses included, but were not limited to, dementia and osteomyelitis (bone infection). An order from the hospital, dated 07/18/11, indicated to change the dressing to the PICC line every seven days, or if heavily soiled. There was a lack of documentation to indicate the order for the dressing change had			

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	been transcribed to the resident's MAR or Treatment Administration Record. During an interview on 08/16/11 at 11:30 a.m., the Assistant Director of Nursing indicated she wrote and transcribed an order to change the PICC dressing every week. 4. Resident #67's record was reviewed on 8/18/11 at 10:45 a.m. Resident #67's diagnoses included, but were not limited to, Alzheimer's disease and chronic kidney disease. An April 28, 2011 Clinical Health Status (an assessment of the residents overall condition to be done on admission, Quarterly, annually, and with a significant change in condition) indicated Section B, Section H, and Section G were not			

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	completed. A July 28, 2011 Clinical Health Status indicated Sections B, C, D, E, F, G, I, J, K, L, M, N, O, and P were not completed. During an interview on 8/18/11 at 11:25 a.m., the ADoN (Assistant Director of Nursing) indicated all sections of the Clinical Health Status forms should be completed. 3.1-50(a)(1) 3.1-50(a)(2)			